

ND RYAN WHITE PROGRAM PART B REQUEST FOR ORAL HEALTH CARE

NORTH DAKOTA DEPARTMENT OF HEALTH DIVISION OF DISEASE CONTROL SFN 58589 (04-15)

Client's Name		ND Ryan White Client Number		
Date Application Completed				
Instructions				
 Please attach estimated cost of procedure from oral health care provider. All procedures will be covered up to 100 percent based on available funding. All procedures besides preventative care will be subject to an oral health care consult to determine the need and if the procedure will be covered by the program. Obtain signatures from your oral health care provider and case manager. 				
Assistance Requested				
Preventive treatment	Filling(s)	Crown/Cap		Oral Surgery
Root Canal	Bridge	Oral Surgery Extr		Extractions
Dentures/Partials	ures/Partials Other			
Dentist's Name Telephone Number				
Defitist 5 Name			relephone Number	
Street Address	City		State	Zip Code
Signatures				
Oral Health Care Provider			Date	
Client		Date		
Case Manager		Date		
ND Ryan White Program Part B Coordinator Approval/Denial				
Approved Denied				